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IN THE UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF PENNSYLVANIA

- - -

AMIR WHITEHURST : CIVIL ACTION

:

vs. : No. 3:17-CV-00903

:

LACKAWANNA COUNTY, et al:

- - -

Friday, March 15, 2019

- - -

Videotaped Deposition of MICHELLE THERSSEN JOY, M.d., taken at Burns White, LLC, 100 Four Falls Corporate Center, Suite 515, 1001 Conshohocken State Road, West Conshohocken, Pennsylvania 19428, beginning at 10:09 a.m., before Barbara C. Stalheim, Certified Shorthand Reporter and a Notary Public.

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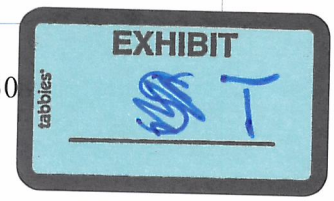
VERITEXT LEGAL SOLUTIONS

MID-ATLANTIC REGION

1801 Market Street - Suite 1800

Philadelphia, Pennsylvania 19103



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EXHIBITS

DEPOSITION SUPPORT INDEX

INSTRUCTION NOT TO ANSWER:
Page Line
(None)

REQUEST FOR PRODUCTION OF DOCUMENTS:
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(None)

STIPULATIONS:
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PREVIOUSLY-MARKED EXHIBITS REFERENCED:
(None)

MARKED QUESTION(S):
(None)

(It is hereby stipulated and agreed by and among counsel for the respective parties that sealing, certification and filing are waived, and that all objections, except as to the form of the question, be reserved until the time of trial.)

PROCEEDINGS

THE VIDEOGRAPHER: Good morning. We are going on the record at 10:09 on March 15, 2019.

Please note that the microphones are sensitive, and may pick up whispering and private conversations.

Please turn off all cell phones, or place them away from the microphones, as they can interfere with the deposition audio.

This is media unit one of the video deposition of Michelle Joy in the matter of Amir Whitehurst versus Lackawanna County, et al., filed in the U.S. District Court in the Middle District of Pennsylvania, Case No.

A. Yes.
Q. -- expert?
A. I was.
Q. Okay. Have you authored any expert reports other than the New Jersey case and the one that we're here today on?
A. Yes.
Q. On how many occasions?
A. I would say including federal, because I do some work for the VA system --
Q. Oh, sure.
A. -- and within the realm of 200 evaluations, most -- predominantly criminal, and predominantly competency evaluations.
Q. Okay.
A. 200 to 300.
Q. Okay. Have you authored reports in medical malpractice cases?
A. No; I have not.
Q. Okay. Would this be the first one --
A. Yes.
Q. -- then?
And the one in New Jersey, was that a medical malpractice case?

A. It was not.
Q. Okay. Okay. I have your CV.
Did you bring a copy --
A. I --
Q. -- with you?
A. -- did.
Q. Okay. Because I -- I only brought one.
Okay. I just wanted to go over some of your -- your background information so I can just get an understanding of what you do today. Okay?
A. Yes.
Q. But, initially, let's just -- can you walk me through your educational background starting with college, and then moving forward into medical school?
A. Yes. So I attended Brown University, and the degree there, instead of a Bachelor of Science, it's called an ScB. They just rearranged the initials, essentially, and that was in cognitive neuroscience. I graduated magna cum laude from Brown University.
From there, I attended Yale for

medical school, and that's where I got my medical degree.
After that, I -- so both -- both of those educational experiences were four years in length.
Q. Okay. So I just want to --
A. Uh-huh.
Q. -- put some dates on it.
At least, according to your CV, you graduated -- you attended Yale from 2008 to 2012; is that correct?
A. Yes; it is.
Q. Okay. And then would Brown have been 2004 to 2008?
A. 2003 -- fall of 2003.
Q. Okay. And then from Yale, you received your medical degree, and then you do postgraduate work.
Where did you do that?
A. I did that at the University of Pennsylvania.
Q. Okay.
A. And that was my psychiatry residency, which was four years in length, followed by a

one-year forensic psychiatry fellowship also at the University of Pennsylvania.
Q. And you completed your forensic psychiatry fellowship in June of 2017?
A. Yes; that's correct.
Q. Okay. During the time that you're doing postgraduate work, are -- are you also, even if you're being supervised, practicing psychiatry?
A. Yes.
Q. Okay. And when did that start?
A. When did I start practicing psychiatry?
Q. (Nods head up and down.)
A. So during medical school, you practice as -- as a medical student, not independently. So that would have been in 2000- -- I believe my first rotation would have been around 2010, but in -- under supervision, and more independently, would have been starting in 2012 as a resident. And -- and during that time, so 2012 to 2013, was half psychiatry. Other -- other rotations included neurology and medicine. And following that, which would have been 2013 on, has been only psychiatry.

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predominantly, I would not see those patients again.
Q. Okay. So what percentage of your time when you were at Fairmount was spent doing the -- I don't know if I'm using the right lingo, but emergency assessment versus the inpatient treatment?
A. 99 percent.
Q. Was the emergency?
A. Yes.
Q. Okay. And then --
A. My role was the emergency assessment. I would just say that occasionally things would come up overnight, but my role was to do the emergency assessments.
Q. Yeah; that's how I was understanding it. I just --
A. Great.
Q. -- wanted to make sure that I was -- I was clear.
Then you have the position at Penn Hospital inpatient and emergency services.
You started that, I guess, in August of 2017, and maintain that position today?

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A. Correct.
Q. And so what is your -- what were -- is the -- do you have the same responsibility today as did you when you started?
A. So this is -- I would -- both that and Fairmount are what we call per diem, or you're --
Q. Okay.
A. -- paid when you go. And so I -- I don't have the same regularity that I had. I am working there less frequently, but I still maintain credentialing, but it would be the same role.
Q. Okay. And so how often, if you can estimate for me, would you see patients at Penn Hospital?
A. During what time period?
Q. Let's start with 2015 moving -- or 2017 moving forward.
If it changed, let me know, because we're -- I guess we're --
A. Uh-huh.
Q. -- talking about a year and a half-ish; right?
A. Correct.

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I would say -- I would say, approximately -- so you -- you work -- for the role that I was in, you work weekends, and so you would cover the entire weekend from Friday night on the phone until Monday morning, and then you're there for Saturday and Sunday. And I would say a weekend shift, such as that, approximately every other month at the beginning, and now I would say I've only done it once or twice in the last year.
Q. Okay. And how often -- I didn't realize that the Fairmount Behavioral Health System position was per diem, too.
A. Yes.
Q. Moving from 2015 -- I guess you were -- I'm trying to figure out the times that you weren't in your fellowship.
So from 2017, moving forward, how often would you -- would you see patients in that emergency assessment position you described earlier?
A. During what -- can you repeat the time period?
Q. Yeah.
Starting after your fell- -- once you

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completed your fellowship.
A. I ranged -- again, I've decreased over time, so I would say originally after fellowship would have been, approximately, once a month, and, again, now I've probably only done it four times in the last year.
Q. Okay. And, just, if you can describe for me in the -- the weekend work at the Pennsylvania Hospital Inpatient Emergency Services, what did you do there?
A. So there, there are two units at Pennsylvania Hospital, two separate floor -- floors, the fourth floor and the sixth floor. The fourth floor has two teams, divided the patients into two teams. That is all acute psychosis work. And the sixth floor is half geriatric patients and half what would be classified as mood patients, and so you see all those patients, which would be 40 patients on Saturday and Sunday, and you can also be called to do consult work in the hospital, but that's less regularly, but you'd see all 40 patients, assess their safety, assess their treatment over the weekend. And, like I said, I was also on the phone supervising the Penn

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emergency room, that is, I would say, 99 percent veterans, but, again, it's focusing on suicide, homicide, psychosis, high acuity patient that come in needing to be seen.

The reason I said that there might not all be veterans is because it's an emergency room. You don't turn someone away --

Q. Right.

A. -- in the middle of an emergency, but predominantly it's veterans because that's who would come to the hospital.

So you also asked when I started versus now. So I originally did a 24-hour shift there. I started at 8 a.m. and continued until 8 a.m. the next day in the emergency room; however, the policies and staffing changed at the VA such that they did not -- they changed their role so that there's no psychiatrists overnight between 11 p.m. and 8 a.m. So now I work 8 a.m. until 11 p.m. in the emergency room, but I'm accessible by phone from 11 p.m. until 8 a.m.

Q. Okay.

A. So that's the sense that my role changed. That was, approximately, one year ago by

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virtue of the policy of the VA that the hours in-house decreased.

Q. And how often would you do this shift, whether it was the 24-hour shift, or now the -- the -- whatever the time is in the hospital?

A. Every week.

Q. One time a week?

A. Yes.

Q. Okay. And then you have on your CV that -- something classified as a forensic evaluator for the Court Mental Health Clinic, First Judicial District of Pennsylvania.

What is that?

A. So when you previously asked about the number of expert evaluations that I have submitted reports for, the majority come from this position. So during my training as a fellow, I started there. For one third of the year during my fellowship I was there, approximately, three days a week. In 2017, when I was hired, I -- I've been there since then between one and twice a week. And those evaluations, again, I would say, upwards ever 90 percent are competency to stand trial, as well as diagnosis and treatment recommendations,

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primarily focused on psychosis; whether or not someone is competent for criminal charges. Once in a while there are evaluations for post-sentencing recommendations for treatment; however, as I said, the vast majority are competency to stand trial.

Q. Okay. Is there any way you can break down when you say "vast majority of competency," can you be more specific?

I don't want you to pull a number up, but is it, like -- when you say "vast majority," I don't know what that means.

So is it, like, 50 percent?

60 percent?

A. I believe I said upwards of 90 percent.

Q. Oh, I'm sorry. I didn't hear you. Okay.

And then the last position that you have listed here is jail-based competency psychiatric evaluator, MHM Services.

I don't know what -- what is that?

A. Yes. So this is a great one to bring up. So there's the ACLU has sued the --

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essentially, the state hospitals in Philadelphia, feeling that psychiatric care in jail is so poor, and we're, essentially, at the bottom of national standards for psychiatric care in jail in Pennsylvania. And so the ACLU has sued, and me, and three other doctors, were hired as the independent assessment experts in this case to see every person in the state hospitals at Norristown State Hospital and Torrence State Hospital to make recommendations about where the placement should be. So the case is, essentially, that there's such a long wait to get treatment in jail, psychiatric treatment, to the state hospital, and that treatment in jails in Pennsylvania are substandard. And so they need assessments at the two state hospitals to get patients out of the state hospital into alternative settings so that people can be moved from the jail to the state hospitals for appropriate treatment.

Q. Okay. And who -- you said you were hired.

Who hired you?

A. MHM Services.

Q. Who's that?

the initial evaluation, you may not know, at that time, whether the psychosis is a result of Spice or something else.

A. Correct.

Q. Okay. And then, as part of your practice then, do you, also, treat patients who, at one point or another, was determined that their psychosis was the result of the Spice?

A. Yes. I would say even in those cases it's hard to distinguish. I would put them in several categories, whether it was substance induced, substance enhanced, whether there was an initial psychosis that was worsened by -- by Spice, or other synthetic cannabinoids, or other drugs. And I think, for the most part, we don't look too far into it because if the psychosis continued, even from the beginning, they'd get the same treatment.

Q. Okay. But are you able to estimate -- and if you can't, just tell me that, too -- how much patients that you do follow-up care in who have psychosis that at least the working diagnosis is as a result of Spice?

A. No; I can't make an estimate.

I can say one of the patients that I saw -- let me see. One of the patients that I saw on Wednesday who -- sometimes I will see the same patients in the emergency room that are also on my outpatient team, he jumped out of a window and broke both of his legs with what we're assuming was substance-induced psychosis.

Q. Okay.

A. So there are people, but, again, I can't make an estimate of how many.

Q. Okay. And when you have a person who you believe is suffering from psychosis from Spice, what is the -- generally speaking, what is the treatment plan?

A. So the treatment plan would be -- for psychosis, in general?

Q. Psychos- -- okay. Does it make a difference for you -- I guess that's one thing I should ask you before we get into the treatment.

Does it make a difference for you, as a psychiatrist, if you're treating a patient who has a psychosis that is not believed to be as a result of Spice?

A. It does not make a difference for me.

Q. Okay.

A. I would say that the difference is the acuity of the psychosis and the symptoms and the safety requirements, but I would treat -- I would assume that psychosis is psychosis, and I wouldn't make that differentiation in terms of the medications that I would prescribe.

Q. Okay. And so is the -- the initial treatment for someone -- a patient that you're seeing that has acute psychosis medication initially?

A. Is the treatment for acute psychosis medication?

Q. Yes; is that part of it?

A. It is part of it; yes.

Q. Okay. And what is the medications that are prescribed?

A. Well, wonderfully, there are a wide range of medications that can be prescribed. I would say --

Q. Maybe you can give me, like, I don't -- you know, aspirin versus Tylenol.

A. Right.

Q. Do you know what I mean?

A. So two -- two main categories. The standard of care would be to prescribe an antipsychotic and/or a benzodiazepine. And within those categories there are numerous options, some of them are intramuscular, as well, and some are by mouth. So those would be the two classes of medications that I would prescribe for acute psychosis irrelevant of the cause.

Q. Okay. And would those medications also be part of the treatment regimen, same kind of patient we're talking about back in 2015?

A. Can you repeat the question?

Q. Yeah.

So we're still talking about the same kind of patient --

A. Uh-huh.

Q. -- who has psy- -- acute psychosis that Mr. Whitehurst was treated in May and June of 2015.

So I'm just wondering if the treatment would have been -- would have included both the antipsychotic and the benzodiazepine medication.

A. Yes.

Q. Okay. And then you said, also, that

A. Yes.
Q. -- testified to that under an appropriate circumstance, restraints have an appropriate -- are an appropriate mechanism in psychiatric treatment to stabilize a patient?
A. Yes; with those caveats. Because they also can cause significant harm, and so we try to limit the amount of time in restraints and get people out of them as quickly as possible.
Q. Can you just give me a sense of, since your fellowship -- we went over what -- all the various positions that you hold today.
Just, I want to get a sense of what is your typical week like.
A. Uh-huh.
Q. Like, where -- where are you?
A. So Monday and Tuesday I'm in the VA outpatient clinic, the silver team, which is the psychosis, seriously mental ill team, and this is -- some weeks might vary, but I'm going to give you the typical weeks.
Q. Okay.
A. So a 8 a.m. until 6:30 p.m. on Mondays, and then 8 a.m. until 4:30 p.m. on

Tuesdays. Wednesday, 8 a.m. until 11 p.m. I'm in the emergency room, and then I'm available overnight between 11 p.m. and 8 a.m. at the -- for the -- for the VA Hospital emergency room. Thursdays, typically, I'm in the courthouse for the competency evaluations between 11 and 2, doing three evaluations during that time period. And the rest of the week will vary if I have students, because I train all the students in forensic psychiatry -- all the residents, I'm in charge of training them in forensic psychiatry. So sometimes I'll add additional days if they're on rotation with me. And then between Friday and Sunday I might do another day at the courthouse. I might be at Norristown. I might be participating in some forensic evaluation, and occasionally moonlighting.
Q. So how many hours a week do you work, typically?
A. So --
Q. I understand they vary.
Can you give me a range?
A. Yes. Thirty-three hours at the VA on-site. Eleven p- -- nine off-site. Is that

right? Nine off-site. Three at the courthouse. So I would say minimum of 43 hours --
Q. Okay.
A. -- somewhere.
Q. Okay. Okay. And did you -- I -- did you have an opportunity -- I sent a Notice of Deposition for you to come here today.
A. Yes.
Q. Did you have an opportunity to look at it?
A. Yes.
Q. Okay. And did you -- I see that you're -- you're not a paper person, you're a computer person --
A. This is correct.
Q. -- but did you -- at some point, I'll have to get copies of it, but did you bring with you -- and I'm just going to read off, just to see --
A. Uh-huh.
Q. -- what we have. I asked you to bring a copy of your report, which is December 31, 2018. I -- I have one.
A. Yes.

Q. So that's not that big of a deal.
A listing and description of all documents and materials that you reviewed to prepare the re- -- report?
A. And that is in my report at the end.
Q. Okay. So it's -- it's the last page; I think?
A. Yes.
Q. That's what we're talking about?
A. Yes.
Q. Have you reviewed any additional documents since you prepared the report?
For example, I know there were depositions taken, maybe, two weeks ago, three weeks ago.
Dr. Evans, did you read his deposition?
A. No.
Q. And then there's also a psychologist, Dr. -- I'm going to brutalize it -- Deesh (ph)?
MS. SHWED: Is that how you say it?
MR. PARKINS: Are you talking about Sisti?

see his CV?
A. Yep.
Q. My highlighting is just my reminders. You can --
A. Yes; I have not seen this.
Q. Okay. So take your time, and look at it; if you like.
A. I've briefly reviewed it at this point.
Q. And that's all I wanted to ask you is that, at least, if -- if you assume that all of the documentation in that curriculum vitae is accurate, and I think he testified to it, too, but the deposition will reflect that, that Dr. Mallik is a licensed psychiatrist to practice in the Commonwealth of Pennsylvania, and he's been practicing psychiatry for, approximately, 22 years?
A. Yes.
Q. Okay. And can we agree that on -- in the Commonwealth of Pennsylvania, in order to practice as a psychiatrist, you do not need to be board certified?
A. That is my understanding --

Q. Okay.
A. -- correct.
Q. And so can we agree then that a psychiatrist who's practicing, who has a license to practice in the Commonwealth of Pennsylvania, does not breach the standard of care simply because he doesn't have a board certification?
A. Not in and of itself; that is correct.
Q. Okay. Can I have that back --
A. Yes.
Q. -- just so I can keep my stuff.
Okay. And then, at -- at least according to his curriculum vitae, since July of 1997 until present day, he's been a psychiatrist at both the State Correctional Institute at Waymart, which is the state corrections back in Lackawanna County, and the Lackawanna County Prison; if this is --
A. That is on there.
Q. Okay.
A. Again, I have no idea how much time he's spent there. If six hours a week counts as --
Q. It does.

A. -- being there are continuously.
Q. Yeah. And I'm not representing the time.
A. Okay.
Q. I'm not representing hours, but -- and he did testify to that, that he has continuously provided psychiatric care from -- to inmates from 1997 until -- he continues to do it today.
Do you recall him testifying to that, or no?
A. Yes.
Q. Okay. And then in addition to that, he also practices in private practice with Dr. Burger and his group.
A. I do --
Q. Do you recall that?
A. -- recall that.
Q. Okay.
A. And I believe a nursing home is part of that, as well --
Q. Correct.
A. -- from his testimony.
Q. Okay. And do you have an understanding, as it relates to the -- the

treatment of Mr. Whitehurst, that Dr. Mallik was not an employee of the Lackawanna County Prison?
A. He was contracted --
Q. Yes.
A. -- is my understanding.
Q. He -- he was a general contractor. So he's not an employee of the Lackawanna County Prison.
Was that your understanding?
A. Yes; it was.
Q. And that he also, similarly, is not an employee of the Correctional Care. He, similarly, had a contra- -- you know what, let me just correct it. He, actually, didn't have contract with the Lackawanna County Prison. He had the contract with Correctional Care.
Do you recall that?
And Correctional Care has a contract with Lackawanna County Prison.
A. Can you repeat the specifics again --
Q. Sure.
A. -- just so I make sure we're on the same page?
Q. I think what Dr. Mallik testified to

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you've reviewed, up to and including today, that he limits the amount of time that he spends to the Lackawanna County Prison to exactly nine hours when he's physically on-site?

Do you know one way or the other if he does that or not?

A. I don't understand what you mean by if he limits it.

Q. So are there times when you're at a facility where you stay longer because you may need to complete an evaluation, or an emergency patient comes in, and to -- to complete an assessment, you stay longer than what, maybe, your allotted times to complete the task; whatever it may be?

A. Yes.

Q. Do you know if there are occasions when Dr. Mallik does exactly that?

Even though he's supposed to be there at least nine hours a week, do you have information one way or the other if he does exactly what I described, that he stays later because someone may come in, he needs to see the patient, or he's involved with a prisoner, and,

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you know, say he's leaving at three o'clock, the clock strikes three, but he continues to stay later to finish -- finish the treatment or assessment?

A. I do not know what he does --

Q. Okay.

A. -- in that regard.

Q. And then, at least according to the contract, and Dr. Mallik's deposition testimony, in addition to the time that he is physically on-site that week, he also is available for phone calls in emergency-type situations, as described in the question I just read to you?

A. That's my understanding of what you read, but I would say I'm unsure of what he could do remotely since they don't have an electronic medical record. When I'm available overnight, I log onto the computer. I can see everything about the patient, their entire history, and I can order medications. But since they have a written medication, you know, they -- all of his orders are done handwritten, so I don't know what he could do by phone.

Q. He can't do a verbal order for

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medication?

A. I don't know.

Q. Okay. So you don't know one way or the other?

A. Right.

Q. But are you aware in practice that there are times when physicians and psychiatrists do verbal order medication because they're not physically on the site?

A. It's tended to move away from that. Most of the places that I work for don't practice that way anymore because you don't have information about the patient, you're not able to see them, you don't have there are records, and you wouldn't, for instance, know if they have allergies, or anything else. So I know that it is -- it does happen, but I know that they're moving way from that with the preponderance of electronic medical records in order to enhance safety and better care.

Q. Okay. But it's not a breach of the standard of care for a physician to provide a verbal order today; am I correct?

A. Is it a breach of the standard of

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care?

Not inherently, but if it's not now, it soon is going to be.

Q. Right.

But you understand that you're here to testi- -- I -- I understand the trend.

A. Uh-huh.

Q. And when you practice in a city situation like you do in Philadelphia, the technology seems to be more advanced than from places like Lackawanna County where we may linger a little behind. But the standard -- once you're -- the standard of care, as I understand it, is that I always refer to it to the jury is the floor, not the ceiling.

A. Uh-huh.

Q. So it's the minimum requirement of a physician similarly situated in a similar circumstance; correct?

Is that your --

A. That is my --

Q. -- understanding?

A. -- understanding.

It is an agreed-upon standard, not the

Q. (Nods head up and down.)
A. No; I did not.
MS. SHWED: Okay. Do you want to go off the video record for a minute?
THE VIDEOGRAPHER: Time is now 11:11. Going off video record.
- - -
(Whereupon a discussion was held off the record.)
- - -
THE VIDEOGRAPHER: Time is now 11:13. Back on the video record.
BY MS. SHWED:
Q. Okay. Dr. Joy, we took a -- a few-minute break off the video record so that you would have an opportunity to review the December 12, 2013, letter from Shirley Moore, M-O-O-R-E, and her last name is Smeal, S-M-E-A-L, executive depth secretary, and the other letter also authored by her on September 25, 2015; right?
A. Yes.
Q. Okay. Did you -- is that the first time that you had an opportunity to read those records?

A. It is.
Q. Okay. And so you did not, obviously, have that information prior to you preparing your report on December 31, 2018?
A. Correct.
Q. Okay. Did you also have an opportunity, prior to preparing your report, to read the deposition of the warden in Dec- -- in 2015, Robert McMillan?
A. I did not.
Q. Okay. The -- the letters -- and I'm just going to read some of them for you.
This letter, December 12, 2013, is addressed to Corey O'Brien, who was the Lackawanna County Commissioner at the time, and it says -- and I'll read it all to you because both letters are the same.
Congratulations are in order as the Lackawanna County Prison has earned the 2013 Certificate of Compliance. Warden Robert McMillan, and the Lackawanna County correctional staff deserve credit for their efforts in operating this facility in accordance with statewide correctional standards. There are no

deficiencies, or citations, to this report.
The Pennsylvania Department of Corrections Office of County Inspection and Services, Director Thomas G-R-E-I-S-H-A-W, inspectors Sandra L-E-O-N-O-W-I-C-Z, and Joseph F-E-R-R-A-N-T-I conducted the inspection of the Lackawanna County Correctional Facility on October 3, 2013. The results of the inspection show that the facility has achieved a hundred percent compliance with Title 37, Chapter 95 County Correctional Institutions Administrative Standards Regulations and Facilities.
Staff commitment to compliance was evident throughout the facility, allowing the facility to maintain an audit-ready status. Staff at the Lackawanna County Prison should be proud of their accomplishments and are encouraged to maintain this level of compliance.
Receiving the Certificate of Compliance is a distinction that is earned when a facility and staff have met, or exceeded, the Department's expectations. Due to this achievement, the Lackawanna County Prison is exempt from the normal one-year inspection cycle.

As such, the next inspection cycle for this facility will be 2015.
As the executive deputy secretary, I extend my congratulations and gratitude to all involved for their outstanding inspection results and a job well done.
And it's pretty much an identical letter dated September 25, 2015, except that this references that the next inspection cycle will be 2017.
And have you ever had an opportunity to review what's referred to in this letter as Title 37, Chapter 95, County Correctional Institutions?
A. No.
Q. Okay. I'm just going to read for you some of the things that are included as the administrative standards and regulations for the facilities. Those include personnel, orientation, inmate rules and staff procedures, medical and health services, security and treatment services, among others. Okay?
And, Doc- -- and, lastly, until I get into the question that I do want to ask you, with

those letters; yes.
Q. And to -- and that letter is based, of course, on the state's inspection?
A. Yes.
Q. Okay.
A. Again, like I said, my understanding from my work in the -- in the -- in the ACLU case is that -- that says we have compliance with our state regulation, I believe, but the content of that lawsuit is that we're pretty much the worst in the -- our state is the worst in the country for our treatment in jail for mental health, so...
Q. But the people who are -- or, you won't disagree with the fact that the people who are in charge of ensuring that the Department of Corrections regulations, administrative regulations, are being followed, go out and do the inspections, it's their sole purpose in going out there is to determine whether a particular facility meets the regulations or not; correct?
A. Yes.
Q. And that inspection has the ability to find deficiencies and write citations for those deficiencies if they -- they see it and they deem

it appropriate; correct?
A. Yes.
Q. And based on the two letters that we saw, that did not happen in the Lackawanna County Prison in 2013, and it did not happen in 2015; correct?
A. Correct.
I wish it had because some things might have improved.
Q. Is -- in -- it's my understanding that you intend to provide expert opinion as it relates to Dr. Mallik as to whether he breached the standard of care from May 25, the time that Mr. Whitehurst was brought into Lackawanna County Prison, to June 8, 2015; is that right; when he went to -- he was then transferred to the Geisinger CMC?
A. Correct.
He was transferred on June 9; I believe.
Q. Yeah. The last time that Dr. Mallik saw him would have been the day before.
A. Correct.
Q. Okay.

A. But I would say into June 9 because I think he should have had more frequent visits. I just want to extend it to that time period.
Q. Well, he was taken to the hospital in the morning hours, right, of June 9, was that your understanding, it was, like, nine o'clock?
A. I'm not sure what time, but...
Q. Okay. Do you intend to provide opinions as to the causes of the medical conditions that brought Mr. Whitehurst to Geisinger CMC on June 9?
A. I -- insofar as I'm a medical doctor, I can provide some opinions largely based on my review of the hospital records and their conclusions.
Q. Are you -- I guess -- you know, in the medical malpractice realm, we call it causation.
Are you intending to provide causation testimony as it relates to the medical conditions that brought him to Geisinger CMC?
A. Yes.
Q. Okay. Did you have an opportunity to -- to review the discharge diagnoses from Geisinger CMC?

A. Yes.
Q. Okay. Can you tell me what in -- opinion you intend to provide was the cause of Mr. Whitehurst's hyperkalemia?
I'm just going to read off the diagnoses --
A. Uh-huh.
Q. -- that are on the discharge summary.
A. So when you asked me, I don't think that I would provide them for each and every diagnosis.
Q. Okay. I'll go over them --
A. Okay.
Q. -- and if you don't, just tell me you don't.
A. Okay.
Q. So I'm getting from this answer, at least, you don't intend to provide an answer as to what caused Mr. Whitehurst's hyperkalemia?
A. Correct.
Q. Drug-induced thrombocytopenia, T-R-O-M-B-O-C-Y-T-O-P-E-N-I-A [sic].
A. Correct; I will not be providing an opinion there.

non-environmental; so I can see that.
Q. Right. I can read that, too.
Okay. Can I ask you, did you have any documentation to suggest to you that Mr. Whitehurst had a mental health diagnosis coming into the Lackawanna County Prison on May, I think it was 25th of 2015?
A. When you say "coming into"...
Q. Was there some psychologist, or psychiatrist, who diagnosed Mr. Whitehurst with a mental health diagnosis prior to his being brought into the Lackawanna County Prison on May 25, 2015?
A. I believe that he had had interaction with psychiatry at some point, but I don't know -- I didn't see those --
Q. Okay.
A. -- reports.
Q. And when you say that, I don't remember seeing one.
So what -- what information are you talking about?
Where -- again, I saw stuff after, but I'm not certain that I saw anything before the prison in Lack- -- the Lackawanna County Prison in

May of 2015.
So can you be more specific about what you saw that suggests that he was seen by a psychiatrist before then?
A. Yes; I believe it was in his deposition he talks about having seen a psychiatrist prior.
Q. Okay. About -- how about as far as psychiatric records --
A. No.
Q. -- or treatment records?
A. No. Not at all.
Q. Okay. And I think in his deposition he referred to a psychiatrist who -- I forget if it was psychiatrist or psychologist, Dr. Fishbein; is that what you're talking about?
A. No. That was specific because I believe he -- let me see when that report was. Give me one moment.
Q. Oh, yeah. Take your time.
A. My understanding was that he had seen an additional psychiatrist at some point prior to his entering into the prison.
Q. Is it strictly from

Mr. Whitehurst's --
A. Yes.
Q. -- deposition --
A. Yes.
Q. -- that you're recalling that?
A. Yes.
Q. Okay. I know in your report you -- you talk about when Mr. Whitehurst was able to get cognizant again that he recognized the difference in his physical appearance.
Do you recall that?
A. Yes; I do.
Q. Okay. Do you know what page that's on?
A. Yes; it is on page 11.
Q. Okay. All right. I think I get to that later, but I will -- let me just make sure I write that down so I know.
So then let's talk a little bit about Dr. Mallik's involvement with Mr. Whitehurst. Okay?
A. Yes.
Q. You -- you know, at least from reviewing the records, that Dr. Mallik saw

Mr. Whitehurst on May 25, 2015, according to the documentation; right?
A. I couldn't read any of it, but assuming that he writes that he saw him, there is progress notes.
Q. Did you get -- his reading -- his writing is difficult to read, so he transcribed it for the litigation.
Did you get to see that?
A. No.
Only --
Q. Okay.
A. -- my understanding of it is largely from his testimony --
Q. Okay.
A. -- from his deposition.
Q. Okay. So you do know, at least either from the documentation, or his deposition testimony, that he saw -- that Dr. Mallik saw Mr. Whitehurst on May 25, 2015.
Does that seem right?
A. Yes.
Q. On May 28, 2015?
A. I don't have the exact dates in front

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Q. Right.
And when a person does a psychiatric, or psychological, evaluation, part of that evaluation, when you can, is an exchange with the patient; a verbal exchange with the patient; correct?
A. Yes.
Q. You try to get the patient to -- you ask certain questions, and you try to get the patient to answer certain questions; am I correct?
A. Yes.
Q. And that type of interaction will help you, as the psychiatrist, try to figure out what an appropriate diagnosis may be for a patient?
A. That is part of the --
Q. Okay.
A. -- evaluation; yes.
Q. Can we agree that it is, at times, difficult to evaluate a patient who will not provide that information to you for whatever reason?
A. What do you mean by "difficult"?
Q. If you're not provided the answers to your questions, it's difficult to come up with a

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psychiatric diagnosis?
A. No; I do not agree.
Q. So you don't need the patient to interact with you at all to come up with a psychiatric diagnosis?
A. So "interaction," you -- by that, you mean verbal?
Q. Yes.
A. You can use a number of different data collection means, and you would not need, necessarily, answers to questions; correct. In a large portion of the patients that I see that are acutely psychotic, they may -- may not be providing information. In fact, there's a specific type of psychosis called catatonia where the patients don't speak.
Q. And in the patients who can speak --
A. Uh-huh.
Q. -- they're speaking, they're just not responding to your questions, are you able, if they don't respond to your questions, to come up with a definitive diagno- -- psychiatric diagnosis?
A. Yes.

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Q. And how do you do that?
A. So my training is in evaluating signs and symptoms of mental illness, and that would include appearance, behavior, speech, monitoring of emotional range, thought content, whether someone is responding to internal stimuli, responding to hallucinations. It would include their psychomotor activity -- this is called the mental status exam, and only one part of that entire exam is based on what the patient says, which is mood. And so the entire exam, only one word of it is what the patient says.
Q. So in someone like Mr. Whitehurst's case where there were descriptions of him -- I think you saw the video.
A. I did.
Q. All right. So you saw some of the activity. And there were some descriptions in the Lackawanna County Prison notes of him talking to the toilet, talking to spirits, those types of things.
So based on your observation of the video, and the reading of some of the deposition testimony and the records of what was going on

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with Mr. Whitehurst, would psychosis be one of the things you would diagnose him with?
A. I would have said unspecified psychotic disorder. I know that Dr. Mallik wrote psychosis nos. But I -- this was 2015. That wasn't a diagnosis in 2015. It changed in 2013.
Q. Okay. So would -- yours would have included the psychosis, not -- not otherwise specified; is that what you said?
A. Mine would be unspecified psychotic --
Q. Unspecified.
A. -- disorder. Not otherwise specified was no longer a diagnosis as of 2013.
Q. Okay.
THE VIDEOGRAPHER: Counsel, just so you know, there's about five minutes before I'll have to change disks.
MS. SHWED: Okay. Well, let's take a break now then.
THE VIDEOGRAPHER: Time is now 11:40. This concludes disk one.
- - -
(Whereupon a recess was taken at this time.)

Q. Okay.
A. Which I think the equivalent of Mr. Whitehurst's -- I -- his condition was the equivalent of that at that time.
Q. Well, can we agree Mr. Whitehurst was not in a psychiatric hospital; correct?
A. Because there wasn't one. So the level of observation that he was on was one-to-one observation, and that would actually be equivalent and above the acuity -- one of the highest acuity patients if he were in a psychiatric hospital. He wasn't in a hospital by virtue of the fact that there wasn't --
Q. Right.
A. -- one available at the jail.
Q. Right.
He was in the Lackawanna County Prison; correct?
A. Correct.
Q. And I know you said that -- you reference in your report that, at some point, it was your opinion that Mr. Whitehurst should have been transferred to a different -- out of the Lackawanna County to a different facility.

When did you -- when do you believe that should have occurred?
A. Where did I -- can you tell me --
Q. Oh, maybe I --
A. -- where I say that specifically?
Q. Maybe I misunderstood.
Do you have an opinion that you intend to render at the time of trial that at some point Mr. Whitehurst, during that May 25 through June 8, the last day Dr. Mallik saw him as a patient, should have been transferred to a different facility?
A. My -- the opinion that I will provide with regard to that is that that was one option. There could been a number of interventions that didn't happen. That could have been an option, but it is not the only one.
Q. Okay. So if I understand what you're saying, the fact that he was not transferred out of the Lackawanna County Prison, in and of itself, is not a breach of the standard of care because there were --
A. Correct.
Q. -- other options, in your opinion,

that could have been done in the prison setting?
A. Correct.
Q. Okay.
A. I would characterize my opinion that in and of itself that was not a breach of the standard of care, but not doing anything, I believe, was a breach of the standard of care.
Q. And you said that you knew that he was on the -- he was in the portion of the prison where there was the camera cells; correct?
A. Correct.
Q. Okay. And you knew from when -- Dr. Mallik's testimony is that the practice was that he would have to see every inmate in a camera cell every time he was in the prison; correct?
A. Yes.
Q. Okay. And we read the dates off that Mr. Whitehurst was seen by Dr. Mallik prior to him going to the hospital.
Do you recall?
A. I do.
Q. I think it was, like --
A. -- seven; I believe.
Q. I'm glad you remember.

Okay. So he saw -- when I say "he," Dr. Mallik saw Mr. Whitehurst seven times between May 25, 2015, until June 8, his last visit, 2015; understanding June 9 is when he's taken to Geisinger CMC; correct?
A. Yes.
Q. And you -- you -- do you have an opinion that that did not meet the standard of care, the frequency of the visits?
Let's just stick with that first.
I'm not talking substantively right now. I'm talking frequency of the visits.
A. Again, I think -- I think that in -- in the context of not receiving treatment, and not updating the treatment plan, but in and of itself, he should have seen some mental health provider everyday. It wouldn't have to be Dr. Mallik, necessarily, but it's within the range of what I would characterize as the breach of standard of care, but in and of itself I don't think any fact does that on a solo basis.
Q. And I understand.
I -- I -- we'll get into what you think --

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benefits, treatment planning, options of medications, and things of that nature.
Q. And can a patient who has a diagnosis of psychosis just simply choose not take the medication?
Do they have a right to do that; as you understand it?
A. It depends on the acuity of the situation.
And I just want to respond that in this case he was deemed to be at acute risk of harm to self or others, so the standard of care is to make sure that he has medication to not harm himself or others.
Q. So you would have injected him regardless of whether he wanted it or not, the medication?
A. Well, I wouldn't do it. The nurse would.
Q. I understand.
You would have ordered the nurse to inject the medication whether Mr. Whitehurst agreed to it or not in the setting that you know it to be --

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A. Correct; because --
Q. -- from your review of the records?
THE COURT REPORTER: Let her finish.
BY MS. SHWED:
Q. In the setting that you knew it to be from reviewing the records.
A. Sorry. I got distracted.
Can you repeat that for me?
Q. Yeah; sure.
So I guess my understanding is that it will be your testimony at the time of trial that the standard of care in 2015 required Dr. Mallik to order the nurses to inject the -- either the antipsychotic medication, or the benzodiazepine medication, even if Mr. Whitehurst told them he did not want that medication?
A. Again, it's within the range of options. So you could have considered another by-mouth medication.
Q. And -- okay. And I -- I understand.
I guess what I'm trying to figure out is do you intend -- the purpose of a discovery deposition --
A. Uh-huh.

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Q. -- is so that I understand what you intend to testify to at the time of trial. And so that's what I'm trying to figure out.
A. Uh-huh.
Q. And so when you say to me there are other options, so I want to figure out, is it specifically your testimony to a reasonable degree of scien- -- psychiatric certainty that, as you understood Mr. Whitehurst's condition to be in that week or so, May 25 to June 8, 2015, that the standard of care required Dr. Mallik to order a nurse to inject the medications you discussed, even if Mr. Mallik said he did not want them [sic]?
A. I think it's a mischaracterization because the standard of care would be consumption of medication in some form. Again, it could have been alternative medications. It could have even been the Risperdal and the Ativan with -- with counseling and discussion of the medication. So I can't say in and of itself that he definitively should have ordered an intramuscular injection, but the patient needed required medication.
Q. Okay. So does the -- did the -- is it

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your opinion to a reasonable degree of psychiatric certainty that in 2015 the standard of care required Dr. Mallik to order a nurse to give Mr. Whitehurst either an injection, or oral medication that you've described, even if he said, no, I don't want the oral medication, and I don't want any injections?
A. Correct.
Q. You -- you believe that because he did not order the nurse do that, he breached the standard of care?
A. Because the patient -- yes.
Q. Okay.
A. Yes.
Q. Do you believe that a psychiatrist has the ability to force a patient diagnosed with psychosis to take medication via injection, or orally?
A. Only in situations where they're at an acute risk of harm to self or others, which is well documented in the record.
Q. We talked a little bit about what I referred to, or what Dr. Williams refers as the patient load. That was the 75 to 100 --

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for example, is always going to be a history.
Q. I'm not talking about substance abuse.
A. Okay.
Q. I'm talking about mental health issues.
Can -- can -- you just said to me that there are lawyers who have psychosis --
A. Uh-huh.
Q. -- correct?
So the lawyers who carry a diagnosis with psychosis do not need to be seen every single day. They can go out in the world, and they can practice at lawyer -- as lawyers without having to see a psychiatrist every day; correct?
A. That is correct.
But I also want to say you said -- you were talking about mental health and not substance abuse, but substance abuse is within the realm of mental health, and Dr. Mallik was charged with seeing patients with substance abuse, as well. So I don't want to distinguish those who are trained in substance abuse.
Q. I'm talking about -- we're going to get -- I'm talking now about mental health

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patients.
The point I'm trying to make is that there's no way that you can tell a jury, when you're called to testify at the time of trial, there was prison inmate Smith --
A. Uh-huh.
Q. -- and he was being treated by Dr. Mallik for schizophrenia --
A. Uh-huh.
Q. -- on June 1, 2015. There's prisoner Brown. He was being treated for psychosis by Dr. Mallik on June 10, or whatever date.
That data simply doesn't exist for us to be able to provide that information to the jury; correct?
A. Correct.
I wish it did.
Q. Okay. So as you sit here today, at least for the week that's relevant to Mr. Whitehurst, you don't know if Dr. Mallik saw ten patients, 20 patients, 150 patients. You -- you don't know that. The best you can do is statisti- -- statistically try to figure out.
A. What do you mean by "statistically"?

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Q. By looking at the numbers because you don't know the people he treated.
A. So you're saying that by looking at the numbers, I can't know the numbers?
Q. There's no way you can actually know who he treated, and for what reason, and how long he spent with any of those inmates, from May 25 to June 8, 2015, because you don't know who they are.
A. Partially incorrect, as well, because I can see from his documentation, for example, all of his notes only have three words for what the patient said, which indicates to me that you document everything that happens with a patient, and so it looks like he only had enough of an interaction for three words.
Q. Well, you -- you -- in -- in fairness to Dr. Mallik, you don't know how long he -- he spent with any of the patients that he was seeing in the prison in that May 25 to June 8 time period; right?
You don't know who they are, and you don't know how long he spent.
A. I know how long he spent with Mallik was enough to have a three-word interaction each

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time.
Q. No. They're two different things.
You're judging him based on the content of his note. I get that. But you do not know, as you sit here today, how long Dr. Mallik spent with any of the prison patients he saw for that week. You just simply don't know.
A. Well, standard of care is to document your interactions. It was also in the --
Q. My question is not standard of care. My question is very simple.
As you sit here today, can you tell me how much time Dr. Mallik spent with any of the patients he treated from May 25 to June 8, 2015?
A. Yes; I can tell you for Mr. Whitehurst.
Q. How long did he spend with him on May 25, 2015, by minutes, or seconds, or hours, however you want to say.
A. I would say it's on the order of minutes.
Q. How do you know that?
A. Because he has a very, very brief note that has --

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say that she can somehow testify to a reasonable degree of scientific certainty based on the number of words on a page that she believes he didn't spend a lot of time with him. I get that. She's testified to that. But the reality is, as she just answered, that she doesn't know because the only information she has is that she saw him on -- he saw him on a particular day.

MR. PARKINS: Okay. Well, I'm -- I'm not trying to recap the testimony.

I'm objecting to a specific question.

MS. SHWED: Are you instructing her not to answer?

MR. PARKINS: So to the -- to the extent -- to the extent that there's -- that I'm objecting to the question, obviously, if she understands the question, and she thinks she can answer it, she can do so. If she doesn't feel like she can answer it, she can tell you she can't answer it.

BY MS. SHWED:

Q. Okay. So those are the only facts that you have in the hypothetical.

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A. Can you say --

Q. You know that Dr. Mallik saw Mr. Whitehurst on particular days. They're documented in the records. I won't go over to dates anymore.

A. So this is reality now?

Q. No; this is my hypothetical.

Dr. Mallik saw Mr. Whitehurst on I think you said we counted seven days. Assume that for this hypothetical. That's all you know.

How long did he see him each day?

A. I can't answer that question.

Q. You don't -- you -- you're not able to answer it because you don't have enough information; right?

A. In a hypothetical in which I'm not --

Q. Yes; in a hypothetical.

A. -- presented information.

Q. No; in the hypothetical that you don't have enough information based on my hypothetical that I've asked you to tell me the amount of time that he saw this patient; correct?

A. Say it again, please.

Q. I didn't provide you enough

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information in the hypothetical that I just asked you for you to be able to determine the amount time Dr. Mallik spent with Mr. Whitehurst.

A. I --

Q. That's why you can't answer it; right?

A. I can't answer it; correct.

Q. Why can't you answer it?

A. Because there isn't the information that I would need to answer it --

Q. Right.

A. -- in the hypothetical.

Q. Okay. I know that there were also some criticisms that the nurses and the correctional officers were not trained in mental health issues; is that correct?

A. Yes.

Q. What do you intend to testify, specifically, about that?

A. Can you ask me a question?

Q. Yeah. I -- I'm sorry.

Are you critical of the fact that the correctional officers and the nurses did not receive additional training in mental health issues at the Lackawanna County Prison?

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A. Yes.

Q. And what do you in- -- why are you critical of that?

A. I'm critical of that because of a number of reasons. One is that the triage system, as Dr. Mallik testifies -- or, in his deposition says is that most of the patient that he sees, unless he's responding to a sick call, are referred to him by either a correctional officer or a nurse. And if they're not trained on what to look for, or how to communicate their observations, that's inappropriate.

I believe one of the correctional officers said that they use commonsense, which is inappropriate for a triage system, which is, essentially, how he finds his workload. So I think that's inappropriate.

I also know that the standard of care is to have training. And I will refer to my report. So, for instance, they have those screening instruments that we have in the record. We have no sense that they were trained on how to use those screening instruments. I can't even tell how well they're performed. They are ref- --

three ways that Dr. Mallik had -- would get, I'll call them, referrals. The prisoners --

A. Yes.

Q. -- could ask themselves to be seen; correct?

There was a mechanism by which they could write to the medical department and that they could ask to be seen by a psychiatrist; correct?

A. Yes. The sick call form; I believe.

Q. Right.

And that a nurse, who would be in the -- both the general population and the, I guess they called it the Delta unit, the camera cells, that nurse who could -- who interacted with an inmate could then refer the inmate to be seen by Dr. Mallik if she thought that that was appropriate; correct? Or he.

A. Yes; that's part of my concern.

Q. And so -- and, also, the corrections officer could do the same thing. When they see a person in the prison whose had -- behavior is concerning, whether it be talking to themselves, or as Mr. Mallik was -- Mr. Whitehurst was playing

in the toilet, talking inappropriate topics, those types of things, the correction officer, if he observed or heard that, could then refer that inmate to be seen by Dr. Mallik, as well; correct?

A. Correct.

Again, that's part of my concern because the correctional officer testified to the fact that it was based on commonsense. And in no hospital, medical, or other system would you ever have triage -- imagine an emergency room, the triage person is up there that's never been trained in how to discuss health problems.

Q. Okay.

A. Specifically, I also want to refer to on page two, there's a notification that Mr. Whitehurst was presented with, but I assume -- I know that it's presented to patients there, at least during that time frame, and it -- it talks about signing up for sick call, and it says the nurse will provide treatment as necessary, and if your complaint warrants treatment by the physician, you will be -- by the institutional physician, you will -- you will be seen at the next doctors line.

So, first of all, they're saying that nurses --

Q. I'm sorry. Where are you?

A. Yea; on the bottom of page two of my report.

Q. Okay.

A. So it says nurses will provide treatment, as necessary, and they make the decisions about whether to refer someone to the institutional physician. And, again, if they are making a triage decision based on no training in mental health.

Q. Was it your understanding that the nurses were doing that for psychiatric patients versus medical patients?

A. That's one of the three systems you just talked about.

Q. But was it your understanding that the nurses were saying for a psychiatric patient, I can treat you versus a -- a physician treating you? Was that your understanding of the process?

A. Well, the process says here that they decide whether they'll see them, or whether the -- the doctor sees them.

Q. My recollection was that the nurses were talking about medical care. So if the -- if the inmate had a non emergent or urgent rash, something, that the nurses could take care of that, and if it was something more emergent, the nurse would say, no, you need to be seen by a physician.

Was it your understanding, based on your review of the documents, that that same process occurred with psychiatric patients?

In other words, a -- a nurse would look at a prisoner, and he would be demonstrating psychiatric, or psychosis, behavior, and the nurse would decide on her own that she would treat that patient?

A. The nurse is deciding when to refer to the psychiatrist based on no training. For example, like you said, it would just be based on they are making a decision about whether the person can access treatment or not. So in and of itself, that is a kind of decision about treatment, whether someone can see a physician or not.

Q. And your specific -- is it -- let me

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medical should be involved in it. And so though they might not order it, and I have nowhere in the notes that Dr. Mallik ordered it, there is, and should be, some involvement with medical staff, as -- as -- even according to their policy.

Q. And when you say "medical staff," who are you talking about?

A. I think it would depend on who was there. I can't say, specifically, at every moment in time Dr. Mallik would be --

Q. Okay. But --

A. -- most appropriate.

Q. Look, who -- who would be the list by title of people you're including in medical?

A. Well, it depends for which part of this. So, for example, a written report of medical condition once restraints are removed --

Q. Yeah; who would that include is your understanding?

A. I think that could be either Dr. Mallik or Dr. Zaloga, but for something like medical checks, ten minutes every two hours, that could be nursing.

Q. And was it your understanding that

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Dr. Mallik saw the patients after they were released from the restraint chair?

A. The patients?

Q. Yeah. I'm sorry. Whoever the prisoner was who was put in the restraint chair.

A. Are you talking about Mr. Whitehurst?

Q. No. Just, generally, was it your understanding that Dr. Mallik saw that -- prisoners after they were taken out of the restraint chair?

A. Well, he's only there three days a week. So it would probably be pretty impossible.

Q. Well, when he's there, of course.

A. I don't know.

Q. Okay. Do you remember him testifying to that at his deposition, that, at 135, says when they get released from the camera restraint chair, they're place in a camera cell, and then I see them?

A. So what's the question?

Q. That -- were you aware that Dr. Mallik does see these patients, these prisoners, after they're released from the restraint chair?

A. So going book to him being there

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Thursday, and then Sunday, how soon after -- if someone is taken out on a Thursday evening, how could he evaluate any effects on them until Sunday?

Q. Well, he talked about the -- the ability for people to call him.

Do you remember us going over that early in the deposition?

A. I do remember, but a written report of medical condition once restraints are removed, where is he making the written report, and medical condition should be assessed there. And any hospital I work at, I have to see the person within an hour.

Q. And why is that?

A. To make sure --

Q. No; why is it that you have to see them within -- I understand the purpose.

Why is it that you have to see them within an hour?

Is there a policy that says that, or practice, or regulation?

Why is that?

A. Yes. I mean, hosp- -- most every

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hospital setting that I work in has an internal policy about it --

Q. A hospital policy?

A. -- and it's also -- yes; and it's also standard of care to at least have some type of assessment.

Q. Okay. You also make reference to the National Commission on Correctional Healthcare in your report; correct?

A. Correct.

Q. Is it your understanding that that accreditation is not required under the Commonwealth of Pennsylvania?

A. Correct.

Q. Okay. It's a voluntary accredita- -- the prison, or the jail, may choose to be accredited. They don't have to in the Commonwealth of Pennsylvania.

A. That's my understanding.

Q. Okay. And Dr. Evans was asked, in his deposition, and I know that you did not -- I think you said you didn't have an opportunity to review his testimony; is that right?

He's the -- he's the plaintiff's

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of what an institution would look at to make sure that they are meeting the standard of care.
Q. Do you think --
A. There is no thing that is more authoritative that someone would refer to in terms of establishing policies and procedures. So like I said, they cannot establish this is what you have to do, every single thing in this, and that's the only way to meet standard of care, but it's the authoritative guideline in how someone would establish policies and procedures to meet the standard of care.
Q. Do you agree that the -- the regulations passed in the Pennsylvania Code for corrections is the standard of care as it relates to those particular regulations and administrative guidelines?
A. Is this what we talked about the Title --
Q. Title 37, Chapter 95.
A. I can't comment because I don't have those.
Q. You don't have -- do you want to look at them again, or you just don't know as you sit

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here today if they -- they're standard of care or not --
A. You'd have --
Q. -- because you haven't reviewed the code, itself?
A. Correct.
Q. Okay.
A. You gave me a listing of the categories, but I --
Q. Yeah.
A. -- was not able to assess the content of them.
Q. Right.
I just brought the topics that are discussed because it was too big to lug around from Scranton. Okay.
A. I understand.
Q. Can you tell me now, and we're at the end, I promise, because I thought we were going to be two hours, but we're longer than that.
I want you to tell me all the things that you believe were gross negligence on behalf of Dr. Mallik.
A. All of the things?

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Q. Yeah. All of the things that you believe show gross negligence on behalf of Dr. Mallik in his interaction that we talked about that May 25 to June 8, the last time he saw --
A. Okay.
Q. -- Mr. Whitehurst.
A. Can -- just so -- so we're on the same page, gross negligence, can you tell me legally --
Q. Oh, reckless disregard.
A. Okay. Meaning -- okay. I believe that he had a reckless dis- -- disregard for not treating psychosis in a -- in acute state -- such acute state that he was a risk of danger to himself or others.
Q. Okay. Let me stop you there.
What, specifically, do you mean "not treating"?
What are the things he didn't do that you think he should have done?
A. Given the patient medication.
Q. And what meds?
The two we -- the two groups we talked about?
A. I couldn't list them all because

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there's so many options. Just something in those two groups.
Q. What was -- what was the purpose of the meds?
A. To -- multiple purposes. To relieve subjective suffering. To keep the patient safe. To keep staff safe. To be able to have him calmer so that he could do more thorough psychiatric evaluation. To have the patient get out of the restraint chair sooner, which is not the least restrictive means he should have been in. To -- to be able to treat the condition that he was suffering from.
Q. Now, when you say "treat the condition," what do you -- what do you mean?
Is it what you just -- I just want to make sure I'm not missing part of --
A. Uh-huh.
Q. -- your opinion.
Is it something in addition to what you just testified to when you say "not treat the patient"?
A. Say it again.
Q. I need to know -- what I"m trying to

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physically in the ER --
A. Uh-huh.
Q. -- that you're being called to conduct an evaluation as to whether the person requires involuntary commitment.
A. So whether they require involuntary commitment, or whether there's an evaluation for --
Q. Whether --
A. -- for the need?
Q. -- there's an evaluation under that guise.
A. So I can give a ballpark, and then you can tell me if that --
Q. Sure.
A. -- meets --
So the VA definitely has the least of those. I would say that that is certainly under ten percent. And part of that comes from the reason that a lot of times people are taken to the closest hospital, which the VA is very specific for, you know, a patient population, might not be the closest hospital. And then I would say for Pennsylvania Hospital and Fairmount, more than

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that, but not the majority.
Q. Okay. In a -- in a scenario where you're in the emergency room, be it at the VA, or at Penn, and a decision is made either to a voluntary admission, or an involuntary commitment, would you follow that patient as an inpatient in those scenarios when you're working in the ER?
A. So usually not, but I'm the only psychiatrist for part of the day --
Q. Okay.
A. -- and so if someone needs anything during that time because it's a 24 hour -- a psychiatrist is always available 24 hours, I might repeatedly see the person, but it's not routine that I see them every day. There are four psychiatrists -- most of this is at the VA, and that's the only time I would see someone on the inpatient unit, not the other settings, and so I -- it would be the exception, not the rule; however, since I'm also in outpatient there, a lot of times it will be a patient of mine who I see then post discharge. They have to be seen within seven days of discharge from hospital. So in that setting, I would see them, but on the outside.

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Q. On the outside. I see.
Are there scenarios, for example, where you will be at home, and you will receive a call from the emergency room from a nurse, or an emergency room doctor, or anyone, outlining the scenario of the person in crisis at hand and asking for a -- a recommendation as to 302 commitment or not?
A. I would drive into the hospital.
Q. Okay. So you would never make that decision over the phone. It's an automatic trip to the hospital for you?
A. Yes; as we have a policy regarding that.
Q. Okay. Are there scenarios where you would ever not see a person in crisis in person before making that recommendation?
A. Before making the recommendation of?
Q. Involuntary commitment, or attempting to do, for instance, like, a 201 voluntary --
A. No.
Q. -- or something along those lines?
A. The -- the state regulation is that they have to be seen within two hours of

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presenting in. So I would never -- for -- for a 302.
Q. Okay.
A. And so, no; I would never do that, and I don't think it's appropriate, and no.
Q. Okay. Going to one of your opinions, you noted, and I think you said it a couple times, I'm not merely a psychiatrist, I'm a -- I'm a medical doctor, what's the -- what's the overlap there; if you could tell me --
A. Yes.
Q. -- that?
A. I just -- I know sometimes people confuse, and I think --
Q. Right.
A. -- it's happened even during the course of today's deposition, confuse psychologist and psychiatrist.
Q. Uh-huh.
A. And so I went to medical school. I did four years of training that all medical doctors do. Anyone that has an M.D., right, we all go to medical school for the same amount time. And that's -- means I can prescribe medications;

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record?
A. No.
Q. Okay. And if Dr. Evans --
A. I don't even know what that would mean.
Q. If Dr. Evans said that the psychiatric progress records here, and the corresponding psychiatric physician's orders, don't, in his opinion, constitute medical records, you would disagree with that?
A. Again, I know you just said it, but I just want to make sure I'm hearing it in its entirety.
Q. If Dr. Evans said, in his opinion, the psychiatric records here, and the corresponding psychiatric physician's orders, do not constitute medical records in this case, do you agree with that?
A. No.
Q. Okay. You and Amy went over it in -- in detail, but -- but there is no dispute that in between May 25 and June 8 of 2015, that Dr. Mallik saw Mr. Whitehurst on seven occasions; correct?
A. You're asking if I'm disputing that

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fact?
Q. Yeah.
A. I'm not disputing that fact.
Q. Okay. As we know from your report, you also reviewed the deposition transcript of Nurse Alexis Moritzkat, and you're aware that she would have accompanied Dr. Mallik on those seven interactions with Mr. Whitehurst between the 25th of May and June 8 of 2015; correct?
A. Did I review that deposition. I remember her talking about a accompanying him, but I can't remember, at this time, if she asserted that it was at each visit.
Q. Okay.
A. I know she said that someone is with him.
Q. Right.
So -- so what we have is, at a minimum, Dr. Mallik is accompanied by either Nurse Moritzkat, or another nurse, when he sees Mr. Whitehurst on these seven occasions; correct?
A. That's what she testified to.
Q. Right.
And then legibility aside, we do know

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that Dr. Mallik had progress records and physician's orders which corresponded with each time that he saw Mr. Whitehurst between May 25 and June 8 of 2015; correct?
A. That's how I've established that that's when he saw him.
Q. Right.
And in addition to -- to those seven progress records, and the corresponding orders entered by Mallik, there are also medicine administration records as part of the chart; correct?
A. Yes.
Q. And that -- those MARs reflect that the nurses, at a minimum, attempted to administer the ordered medications two times per day between the 25th of May and June 8 of 2015; correct?
A. Attempted to administer --
Q. And then they were refused by Mr. Whitehurst; correct?
A. I think the record would indicate that it -- that -- or the MAR would indicate that they, at least, saw him, and that there was some -- I can't say that they attempted to administer

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because I don't know exactly what happened during those times. If, for example, they could have just saw him through the window and said, okay, he's not going to get the meds, but at least they were there in some sense.
Q. Let's see if we can agree upon this.
At a minimum, it is some documentation evidencing an interaction between the nurse and Mr. Whitehurst concerning medication; correct [sic]?
A. I can't establish that it was an interaction that there -- I would agree to the fact that there was a visit at least twice a day.
Q. Okay. A visit by a nurse with respect to administering, or attempt to administer, psychiatric medications ordered by Dr. Mallik through his orders; correct?
A. You said "administer or attempt to administer"?
Q. Right.
I say "attempt to administer" because Mr. Whitehurst was refusing.
That documentation exists?
A. I've seen that documentation. Again,

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treatment for the inmate; correct?
A. To this --
Q. And that you were concerned that the nurses, and the correctional officers, didn't have sufficient training to identify a problem and report it to a medical or psychiatric; correct?
A. That the goal of the system is to make decisions about whether someone has access or not, right, because if -- if the goal were access, it would mean everyone, you know, that has a complaint automatically goes. So I think my fear is that the goal of the system is to make decisions about who can access care and who can't, and that they're insufficiently trained to do that.
Q. Okay. And we know within this scenario that Mr. Whitehurst comes in on May 24th of 2015, he refuses an intake, and then as of May 25, 2015, he sees Dr. Mallik for the first time, and then is seen every two days including up to and including June 8th of 2015; correct?
So this isn't a situation where Mr. Whitehurst was -- somehow had fallen through the cracks and wasn't provided psychiatric care;

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correct?
A. I think he had fallen through the cracks, and was not provided with psychiatric care.
Q. He was under the care of Dr. Mallik, we can agree to that, who saw him seven times.
A. He was -- he had established a doctor-patient relationship.
Q. Which is what the goal of triage, as it relates to a psychiatric problem, is designed to accomplish, getting him under the care of a psychiatrist who is then qualified to order medications and make a medical diagnosis; correct?
A. That is part of it; however, for instance, during those -- all the time outside of those seven times that Dr. Mallik documented he saw the patient visually, it's not just about accessing care in terms of referral. It can be that something is going on in between the visits that he needs to be seen again. That his condition is worsening. It sounds like he gets report -- Dr. Mallik is supposed to get report from nurses and correctional about a number of things, and so it's not just about access care.

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It's about making sure that care is carried through with, and also that updates on the patient's condition.
Q. Which would bring -- so is -- is that your training issue with the corrections officers, or is it triage?
I'm just trying to figure out what --
A. I'm not sure what you mean.
Q. What -- what's the -- where is the -- as it relates to this case, what is your proposed testimony as to the training and what the problems were with the training here that led to Mr. Whitehurst's admission to Geisinger?
A. So I don't think that -- at least with regard to mental health that they weren't trained to provide any updates about his status. That they, perhaps, weren't trained -- there's no evidence that they were trained on, for example, how to encourage a patient to take medication with psychosis. There's specific strategies that nurses in psychiatric facilities use.
I don't know that there was training -- clearly, they missed the fact that he had lost significant weight and was visibly

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medically compromised at a -- a point too late in time. So I don't think they were properly trained or -- to report on that fact to either Dr. Zaloga or Dr. Mallik.
I think that training would have been appropriate -- training was both indicated in the policy, and should be the standard of care, and -- on effects of restraints, on interacting with the staff about restraints, on less-restrictive treatment means for mental health, they -- it doesn't -- other types of restraints, the effects of isolation and seclusion; those type of things.
I think that other than referral to treatment in the beginning, it's all of the interactions outside of the minutes that Dr. Mallik is outside of the door, training could have affected the other 23-plus hours of the day.
Q. Okay. How long was Mr. Whitehurst in the restraint chair?
A. I think that's really hard to determine from the record.
Q. Well, that -- that's what I'm trying to -- to get my arms around. You -- you seem to suggest that there's an excessive amount of time

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THE VIDEOGRAPHER: Counsel, just so you know, there's about five minutes before I'll have to change disks.
Do you want me to just change it now or --
MR. PARKINS: It's up to you.
MS. SHWED: I have nothing else.
MR. PARKINS: I have -- I -- I have questions. I'll be a little bit.
THE COURT REPORTER: I need a break, anyway.
THE VIDEOGRAPHER: Time is now 1:09. This concludes disk two.
- - -
(Whereupon a recess was taken at this time.)
- - -
THE VIDEOGRAPHER: Time is now 1:16. This begins disk three.
BY MR. HEISLER:
Q. Doctor, my name is David Heisler; as you now know. I just have a few questions.
When did Mr. Whitehurst process into the -- the prison?

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A. When?
I want to veri- -- the -- I -- I believe -- I don't want to guess.
Do we have the record?
Give me one second.
The 20- -- it was either the 23rd or 24th of May, 2015.
Q. On the 23rd you indicate in your record that he was not in prison, but he was in a hospital in another setting.
A. Where is this?
Q. On page nine.
A. Okay. I see that.
Q. Is it your understanding that he went into the prison on May 24?
A. Sometime between the 23rd and it -- it could have been late to on the 23rd or on the 24th. I don't remember at this time.
Q. Well, you know he's taken to the hospital on June 9; right?
A. Yes.
Q. Was he observed by a medical professional every day that he was at the prison?
A. He was seen -- I can agree to the fact

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that he was seen, meaning, visually, by a nurse, with no psychiatric training, every day -- or no updated psychiatric training.
Q. But my question was would it be fair to state that every day he was in the prison he was observed, or, as you put it, seen by someone in the medical profession every day?
A. Visually seen; yes.
MR. HEISLER: I have no further questions.
BY MR. PARKINS:
Q. I'm seeing you right now; correct?
A. Yes.
Q. Am I providing you with any medical treatment?
A. No.
Q. Are you providing me with any medical treatment?
A. No.
Q. So is it possible to see somebody without providing them with meaningful care?
A. Yes.
Q. And based on your review of the file, was Mr. Whitehurst provided with meaningful

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medical and psychiatric care on the days that he was there?
A. He was not.
Q. Was he provided with meaningful care on most of the days he was there?
A. No; he was not.
Q. Okay. All right. Now, I'm going to go through, because the way I take my notes is that as Attorney Shwed asked you questions, I take notes. So we're going to retrack what she you a little bit, probably in a similar order, okay, but I'll probably jump around a little bit.
A. Yes.
Q. All right. She asked you about your qualifications.
And -- and can you just, specifically, lay out for the record what your experience is, specifically, in the field of care and correctional facilities?
A. I will use -- I'll give you both educational and clinical and forensic, all aspects of that.
Q. Okay.
A. So as a fellow in forensic psychiatry,

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Q. You can answer.
A. Yes.
THE COURT REPORTER: Can I just remind everybody one at a time.
THE WITNESS: Yes; I am writing the figurative, but the literal PowerPoint in training curriculum
BY MR. PARKINS:
Q. Okay.
A. Let's see.
Q. And let me just ask you. I think we hit the -- I think we hit the big points, so I'll move on, but you -- in 2016, you gave a -- you gave a lecture called "Can a Correctional Facility be a Therapeutic Space;" is that correct?
A. Correct.
Q. What's your opinion on that as to whether or not a correctional facility can be a therapeutic in terms of psychiatric care?
A. Right.
So my opinion is that it's inherently counter therapeutic. It has -- there are elements, such as medications, that can be therapeutic, but it's inherently counter

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therapeutic; I would say.
Q. Okay.
MS. SHWED: I'm sorry. What did you say?
THE WITNESS: I said it's inherently counter therapeutic --
MS. SHWED: Oh.
THE WITNESS: -- but some elements of therapeutic care can be provided, and, kind of, the -- the talk was on the different elements of what can be done, and what can't, and what should be implemented.
I mean, there's a lot of this here, so I will just skip to some things that I think is important is that I was on the American Psychiatric Association Counsel of Psychiatry and the Law for two years. And that's, kind of, the -- so American Psychiatric Association is, kind of, our flagship organization -- professional organization, and I was specifically on their subcommittee for psychiatry and the law.
Actually, I'm working on a book chapter right now, I should be finished with

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it tomorrow, for a book that we have a publisher for, and my chapter is on correctional mental health care.
I think -- oh, I think -- let's see. I -- like I said, I run the forensic rotation for all residents. I developed -- started -- there was no psychiatric -- forensic rotation for Penn residents, and I developed that. So I do the whole curriculum planning for that, which includes corrections. I also teach in the forensic psychiatry fellowship at Penn, largely on ethics, and some of that involves correctional healthcare aspects.
BY MR. PARKINS:
Q. All right. So I'll move on from your CV. We all have a copy.
A. Okay.
Q. In regards to one of your jobs, your job at Fairmount, I think you said you -- you do the evaluations for patients in psychosis in terms of level of care; is that correct?
A. I mean, I would say all of my clinical job you're making decisions about level of care, but definitely acutely at Fairmount, the VA and

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Pennsylvania Hospital. At this point in time, my VA job would be the most consistent form of that consideration.
Q. So would they be patients that are in a similar state as to what Mr. Whitehurst was in when he entered the Lackawanna County Prison?
A. Yes.
Q. And so your evaluation for a level of care, can you describe that?
A. Uh-huh.
Q. Does that mean level of care within a prison, whether or not they're transferred out, or what, specifically, does it entail?
A. For my evaluations?
Q. Yes.
A. So usually they -- for an involuntary it would be an acutely elevated imminent risk of harm to self or others, or inability to care for self, but most relevant is the acuity elevated imminent risk of harm to self or others, and that is -- goes on a number of chronic and acute risk factors. Some of it is from history, some of it's from observation. If it's voluntary, it's, again, whether there is some elevated risk, but the

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have operated on that assumption in the acute setting. I would have treated him as someone that was suffering from severe mental illness.

Q. All right. And in the case of Amir Whitehurst, you said that the frequency with which somebody has to see a patient varies on a case-by-case basis?

A. The patient is one of the factors, and there are also logistical factors.

Q. Okay. And in regards to the case of Amir Whitehurst, do you have an opinion as to how frequently he should have been seen by some sort of psychiatric provider while he was in the prison?

A. Meaning, a psychiatrist?

Q. Why don't you say your opinion in regards to a psychiatrist, in regards to a psychiatric nurse, or other staffing.

What's your opinion regarding --

A. My opinion --

Q. -- any type of staff?

THE COURT REPORTER: Let him finish.

THE WITNESS: My opinion would be aimed for daily evaluations by a psychiatrist

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because that's how it is in a hospital, in any hospital that I've ever been in, or worked in. I understand that there can be recruitment difficulties, possibly, getting a psychiatrist in a more remote setting, or something like that. So there should have at least been someone else trained, such as a physician assistant. There are a number -- physician assistant, nurse practitioner on the other days, and then the -- and then, in addition, the staffing should have been -- the staff should have been trained, the ones that were seeing him, and those -- I mean, in a hospital setting you're, basically, never out of the eyesight of a nurse. So you're in the milieu. A therapeutic milieu involves essentially always being seen by medical staff at all times, including when you're asleep every 15 minutes, and so definitely more than line of sight twice a day by someone with no --

BY MR. PARKINS:

Q. Okay.

A. -- updated mental health training.

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Q. So it was a little bit of a long answer.

A. Yes.

Q. So is it -- am I correct in saying that it's your opinion that Amir Whitehurst should have been seen daily by a psychiatrist, and if not, that at least daily by someone with psychiatric training?

A. Yes.

Q. And, in your review of the case, other than Dr. Mallik, was anybody that saw Amir Whitehurst in that prison competent to, or trained to, deal with his mental health issues?

A. No. My opinion is that they were not.

Q. Now, Attorney Shwed asked you about what a -- a treatment plan would be for Spice-induced psychosis; is that correct?

Do you recall that?

MS. SHWED: I believe I said "protocol."

BY MR. PARKINS:

Q. Or protocol.

Do you recall that?

A. If there was a -- I believe she asked

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if there was an established protocol in 2015 for Spice-induced psychosis.

Q. Okay. And -- and -- and I'm going to get into -- to what the protocol is, but I think you noted in your report, and the defense experts noted in their report, that Dr. Mallik's strategy, or course of treatment, was to give him time and space; is that correct?

A. Yes. And I -- I'm saying for the record that I'm laughing only because I laugh every time that I read that.

Q. Why?

A. Because it seemed so inappropriate, below the standard of care, counter therapeutic, and not treatment --

MS. SHWED: I just want to object to the form of your question, but I was trying to consciously not speak over others.

MR. PARKINS: All right. No problem.

BY MR. PARKINS:

Q. All right. So is there any psychiatric merit to treating someone in Mr. Whitehurst's condition with time and space?

MS. SHWED: Objection to form.

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willing to take it at least one time, would have been appropriate. Asking him if there were other medications that he would prefer. For example, a lot of people that I see don't want to take Risperidone because they see on TV that it causes for the layperson breast imminent. A lot of people have, like, a very bad perception of Risperidone. So I don't know if he had any discussions if there's medications that he would prefer. Usually, I give them -- like I said, I'll give some kind of a would you prefer this one or this one to give some kind of option.

Again, I don't consider restraints to be treatment; however, there was, I believe in the policies at the -- the policies at the prison say that the use of restraints in the chair is the most -- more restrictive than other restraints that are available. So that they could have -- again, not treatment, but could have been in a different less restrictive type of restraint, which, per my review of the record and the video, they didn't try other options.

And then, right, so the way that we think about things in psychiatry, is the biosocial

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model, so things are not just medicine. We're also trained in therapy. And so part of that is verbal de-escalation. We're trained to help de-escalate situations, keep people safe, encourage them to take medications. Motivational interviewing is where if someone doesn't want to do something, you can encourage them to see the benefits of it. We use that a lot. There's the Amador model, which is called "I'm not sick, I don't need help" is the title of the book, and it's, kind of, having discussions with people in psychosis about them seeing the benefits of treatment. So I think that there is a lot of psychological interventions that could happen, as well, which I don't see any evidence of.

Q. So -- so let me ask you.

Any of those less restrictive alternatives, were any of those attempted in this case prior to the use of the restraint chair?

A. My understanding is that they were not.

Q. Do you see any evidence in the record that they were?

A. I can say he did prescribe the

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Risperidone and Ativan once, but that was the only.

Q. But they didn't ensure it was administered?

A. Exactly.

Q. What are the -- the -- the -- the potential purposes of a restraint chair?

A. You mean potential out in the world, or in this case?

Q. Let -- let me ask you.

Treatment is a potential use of the restraint chair; correct?

A. Treatment?

Q. Is -- is treatment a -- for -- although not eight hours, is temporary use of restraints, does, at some point, serve treatment purpose?

A. Restraints, but restraint chairs don't exist anywhere outside of jail settings. So I would say that's not treatment.

Q. Okay.

A. But restraints can be used for short period of time to keep someone safe, alongside other options.

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Q. And -- and -- and I'm not asking whether it's right or wrong, but punishments is a -- is a potentially sort of restraint chair; correct?

A. People could use it for that.

Q. Security?

A. People could use it for that.

Q. Okay. So based on -- on your knowledge of medicine, the law, and your experience in corrective -- correct- -- correction facilities, should a restraint chair be used for punitive purposes?

MS. SHWED: Objection to form.

BY MR. PARKINS:

Q. Okay. You can answer.

A. No; it should not.

Q. Okay. What -- what purposes, in a correctional facility, should it be used for?

MS. SHWED: Can I just have an objection -- an ongoing objection --

MR. PARKINS: Sure.

MS. SHWED: -- to her opinions of things that happen in a correctional institution?

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presents to the emergency room, they said he hasn't been eating.
Q. Okay.
A. So that was either on report of Amir, himself, or on report of the staff bringing him in.
So in addition to him being physically malnourished, there was a statement made that he had not been eating. I don't remember if it was eating or drinking, but...
Q. Okay. And so -- so you talk about someone who presents in the hospital with -- with -- and there -- there -- I'm using different words, but, essentially, malnourishment and dehydration --
A. Yes.
Q. -- correct?
And excessive use of a restraint chair can cause problems with eating and drinking; correct?
A. Yes.
MS. SHWED: Objection to form.
BY MR. PARKINS:
Q. So -- and we already said at some

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point in the record there's a note Amir is in the restraint chair, but no note when he comes out; correct?
A. Correct.
Q. So in addition to the excess of eight hours he spent in the restraint chair, there's other periods of time that we don't know how long he was in there; correct?
A. That's correct.
Q. And so would you say that there's a medical correlation between time spent in a restraint chair and malnourishment and dehydration?
A. Yes.
MS. SHWED: Objection to form.
BY MR. PARKINS:
Q. And, additionally, when you're in a restraint chair, am -- am I correct in saying you, essentially, can't move?
A. Correct.
Q. And one of the things that Attorney Shwed asked you about was this rhabdomyolysis; correct?
A. Correct.

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Q. Did I say that correctly?
A. I knew what --
Q. Somewhat?
A. -- you meant.
Q. And -- and that's a breakdown in the muscle?
A. Correct.
Q. And it occurs from not moving; correct?
A. Correct.
Q. Would that be similar to the inability to move in a restraint chair?
A. Yes.
Which, in fact, I can also say we frequently -- if someone is in restraints in a hospital setting, we know to check CK, creatine kinase, which is one of those things, just because it's so well known, that being in restraints, even the -- the less-restrictive restraints causes rhabdomyolysis.
Q. In order to avoid these complications of the restraint chair, how often should medical evaluate a patient's who's in a restraint chair?
A. So medical, again, can mean a number

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of things.
Q. Be it a nurse, a doctor, someone from the medical department.
A. It should be minimum of every two hours.
Q. Okay. All right. I'm going to move on from the restraint chair. I want to talk to you about the -- about the frequency with which Dr. Mallik was at the prison. Okay?
A. Yes.
Q. We talked about the fact that it changed, at some point in the -- shortly prior to 2015, from six to nine hours a week; correct?
A. Yes.
Q. And so at the time that Mr. Whitehurst was there, we're in the time frame where Dr. Mallik is, on average, spending nine hours a week there; correct?
A. Yes.
Q. And let me ask you this: Is -- based on your review of the population of the prison, okay, is -- is -- is -- is the custom or practice of having a psychiatrist on staff nine hours a week, is that custom or practice adequate or

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A. It would be those two combined.
Q. Okay.
A. Which is also consistent with what the nurse estimated on saying that he was seeing hundreds of -- 400 patients and screening 600 to 700 patients and seeing more than 80 percent of inmates.
Q. Okay. So is -- is nine hours a week sufficient to treat that many patients from a psychiatric standpoint?
A. No.
Q. Would 20 hours be enough?
A. Looking at statistics --
Q. Okay.
A. -- I do not believe so.
Q. Okay. So we're not even close?
A. Not at all.
Q. And you were asked if you were aware if Dr. Mallik would take calls over the phone at night --
A. I was asked that.
Q. -- and put in orders; correct?
A. Yes.
Q. And in the course of practice in a --

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in a correction- -- correctional facility, or at any medical facility --
A. Uh-huh.
Q. -- if that occurs, should there be a note of it in the file?
MS. SHWED: Objection to form.
Let me just put on the record to anything related to a correctional facility.
MR. PARKINS: Okay.
THE WITNESS: Yes.
Sorry. Ask again so I can make sure I understand.
BY MR. PARKINS:
Q. If a doctor is called when they're off or on call and puts an order over the phone, should that show up in the medical record?
A. It has to.
Q. And, in your review of the case, is there any evidence that he was ever called, or placed any order over the phone, in regards to Amir Whitehurst?
A. No.
Q. Attorney Shwed asked you about the Navane that was prescribed.

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A. Yes.
Q. And it was prescribed on his last night in the prison, June 8; correct?
A. Yes.
Q. Did you read the defense expert reports that attempted to blame Mr. Whitehurst's physical condition upon entry into the hospital on the Navane?
MS. SHWED: Objection to form to the extent of the characterization of the expert report.
BY MR. PARKINS:
Q. Any of the four expert reports that I -- I provided you from defense counsel in this case, Dr. Zurad, Williams, Fawks and Hughes, do you recall discussion in those reports --
A. At least one.
Q. -- of Navane as being a potential cause of the injuries?
A. Yes; at least one of them.
Q. Is that at all, in your opinion, medically possible?
MS. SHWED: Objection to form.
THE WITNESS: So when I -- I read

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that, again, I'm just going to have to say I did laugh a little bit because it said it was from -- his decomposition was from an overnight sleep, and I slept last night, and didn't end up hospitalized. So, no, I don't think that could have caused his hospitalization, including the fact that he was malnourished, which happens over a period of time, not overnight.
BY MR. PARKINS:
Q. Is it -- is it possible that the malnourishment, the dehydration, and the muscle breakdown could have occurred overnight as a result of one dose of Navane?
A. No.
Q. And --
A. It could have worsened it, but it could not have caused it.
Q. Okay. And have you run into in -- in the practice of psychiatry before, like, occasions where a patient doesn't want to eat or drink?
A. Yes.
Q. Okay. And do you just say, okay, you don't have to eat or drink?

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Whitehurst comes in with Glasgow Coma Score of four, and, like I said, this table has a Glasgow Coma Scale of three, actually, that's how we think about it. So he was so poorly interacting and so compromised that he -- I don't know exactly what point that he got, he might have been that he opened his eyes. But so he was much worse mentally at that time, had much fewer -- less ability to communicate than during all the times that Dr. Mallik saw him, but still, nonetheless, within the first line of the first person that sees him, my understanding is that he looked visibly malnourished.

BY MR. PARKINS:

Q. Is there any evidence in the record that Dr. Mallik did anything to treat that condition?

A. No.

And I also want to --

Q. Other than -- other than ignore it.

MS. SHWED: Objection to form.

THE WITNESS: Correct.

I also want to say that the -- that

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opening doctor describes him as cachectic, and that's a term that we use, most commonly, to describe end-stage cancer patients because their -- your bone -- I mean, the way we describe it is your skin is so sunken in, that your bones are sticking out. You can use it for other cases, but, like I said, it's usually used for end-stage cancer patients. So they were describing him as visibly malnourished.

BY MR. PARKINS:

Q. You saw the -- the video of the cell extraction on the day he was put into the prison; correct?

A. Yes.

Q. Did he appear to be in that state on that day?

A. No.

Q. And --

A. I said that loudly because, like said, the -- the video I watched after my report was finished, so I was actually astonished to see what appeared to be pretty -- a vastly contrasting state to how he was described on June 9.

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Q. Okay. Did -- and -- and attorney Healey started to talk about it a little bit, but Dr. Mallik, in his deposition, do you recall him differentiating, saying I only treat psychiatry at the prison, I don't handle medical care?

A. I do remember that.

Q. Okay. Is -- is -- would -- would that be -- would a delegation of duties, is -- is -- is that an excuse to ignore medical emergency if you see it; from a medical standpoint as a doctor?

A. Not at all. It doesn't excuse it, and, in fact, for instance, when I'm in the emergency room, which happens every Wednesday, at a minimum for 15 hours, we work alongside the medical doctors, and our policy is to have at least one conversation per shift per patient with the medical doctors to update them about your plan, to make sure you're not missing anything. So, for example, sometimes I might find out during my psychiatric evaluation that the patient hit their head. It would be negligent of me to not inform the medical doctor. They could die if I didn't tell them because they might be bleeding in their head, and if I ignore that and artificially

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separated it, it would be very poor substandard care.

Q. So would you -- would you say you have a duty to either take steps to treat it yourself, or to the advise the on-call medical doctor?

A. Correct.

And espec- -- and going to the case of Amir Whitehurst, my understanding, from the record, is that Dr. Zaloga was not seeing him, and so if you're the only medical provider there, it is in your scope of duty to either treat or refer.

Q. Okay. So is -- is there any evidence in the record that Dr. Mallik treated the condition, or attempt- -- or -- or referred it to Dr. Zaloga?

A. There is no evidence of that. I think there's also evidence from his deposition that he -- he's basically saying that he didn't, either, because he's calling that outside his scope of practice, which I don't agree with. One more thing I was going to say about that. Hold on. No. I forgot.

Q. That's okay.

And in regards to the amount of times

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Mr. Whitehurst when he came into the emergency room at CMC. That's exactly what he has documented in his note as it relates to head, ears, nose and throat; normal, atraumatic, no mass, no tenderness, no adenopathy.

That -- this documentation, authored by the emergency room physician at CMC Geisinger on that day, documents a normal head, ear, nose, throat evaluation --

A. Can --

Q. -- correct?

A. Can I briefly see that because I know I reviewed it, I just want to see -- so this is the portion of -- this is auto populated --

Q. Yeah. This is the physical exam.

A. -- and it -- it -- it contradicts -- so that contradicts the narrative that the physician provided. For example, that would contradict the fact that he's cachectic and the other words that they use to describe him. So it was such an emergency situation that I don't think that they were duplicating documentation. I would go more what he thought was very important to include in the beginning, which was that he was

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malnourished, cachectic and not eating.

Q. Well, is it your testimony that the emergency room physician did not perform a head, nose, ears and throat examination, as documented in this chart?

A. Can I see it again?

I mean, again, right here it says cachectic, and it says --

Q. I understand that's the description.

A. Uh-huh.

Q. My question is very simple. This record documents in the emergency room record of that day of this patient, Mr. Whitehurst, the head, ear, nose and throat examination was normal, atraumatic, no masses, no tenderness, no adenopathy. That's what's documented in the record.

If we believe the words on the page, that's a normal examination.

A. Again, there is concurrent evidence that it wasn't normal, and I don't -- because it was an emergency situation, I would go for the words that the -- the physician documented describing the patient as not what's automatically

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populated.

Q. So for an emergency room physician to not accurately diagnose a head, ear, nose and throat examination would be a breach of the standard of care; correct?

A. I think that they did document it, just elsewhere.

Q. This is where it's documented. Head, ears, nose and throat, normal, atraumatic, no masses, no tenderness, no adenopathy.

Your testimony is you don't believe that that's accurate.

And my question is if your belief is true, and this emergency room physician prepared this report, he breached the standard of care.

A. What's the question?

Q. That when you improperly document a medical record that's inconsistent with patient's physician, that's a breach of the standard of care.

A. Again, I think you're mischaracterizing the documentation; so I can't agree with that.

Q. Neck, supplemental, normal range of

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motion, no thryro- -- thyromegaly.

That's a normal neck examination; correct?

A. Again, it says cachectic, and there --

Q. I'm not asking that. Listen to my question, please.

My question is: Is it a normal neck examination to find the neck supple with normal range of motion?

Is that a normal neck examination?

A. Hypothetically?

Q. Is that -- do those words mean a normal neck examination?

That's all I'm asking you because that's what's in this record. You weren't there at Geisinger, neither was I. So the only thing that we can go by is what's documented in the record. This physical examination documents the neck as being supple, normal range of motion.

That's a normal neck examination; correct?

A. Again, I would believe the parts that the physician wrote.

Q. I'm not ask- -- I'm not asking you to

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it would be impossible to do.
For example, tenderness, you know, you're -- the person is probably not responding. He's not able to respond, necessarily, to that, and that's why you repeatedly evaluate a patient over time as they improve.
The other thing about that was, for example, the cardiovascular normal rate and rhythm, you're going to go by the more accurate assessment, which is the EKG, which is actually giving you a readout of it rather than just using your ears.
Q. Okay. And -- and -- and I think what you said was the information on this one page that was selected from the medical record as a whole, the information on here, you said, is auto populated; correct?
MS. SHWED: Objection to form.
THE WITNESS: Yes.
BY MR. PARKINS:
Q. And by "auto populated," that means a computer automatically fills these answers in --
A. Yes.
Q. -- correct?

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A. And that you can change them, but those are the ones that automatically come in, and they have to be changed, or it would be routine practice to address it in an emergency situation in some other element of that same chart of which is multiple pages.
Q. Okay. And the parts of the chart like the narrative, those are the parts that doctors actually write in themselves based on the situation they're presented; correct?
A. Yes.
Q. And based on what the doctors wrote in this case, Mr. Whitehurst was cachectic; correct?
A. Yes.
Q. And we know that his face, his skin, his temperature, was abnormal in contrast to this; correct?
A. Right.
And even I think it says cachectic there at the top of what -- what purpose would it serve to write it three places. He or she is making it known that he's cachectic at least twice.
Q. Okay.

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A. Which was a visible -- easy to see visibly.
MR. PARKINS: Okay. No further questions.
BY MS. SHWED:
Q. Were you at CMC that day?
A. Say it again.
Q. Were you at the hospital that day?
A. No.
Q. Did you see Mr. Whitehurst on that day?
A. I didn't.
MS. SHWED: No further questions.
THE VIDEOGRAPHER: Time is now 2:22. This concludes this video deposition.
- - -
(Witness excused.)
- - -
(Whereupon the document was marked, for identification purposes, as Exhibit No. 1.)
- - -
(At 2:22 p.m., proceedings were concluded.)

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